Children's Dental Care CORP.
422 Main Street
Stoneham, MA, 02180
Tel: (781)438-0300
Fax: (781)438-0336

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ...(parent's name), have received a copy of this office's Notice of Privacy Practices.

.....
Child's name

....
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (please specify)

.....
.....
.....

Children's Dental Care
Badrieh Edalatpour, D.M.D.

PATIENT INFORMATION:

Patient's Last Name _____ First Name _____ Home Telephone _____ Birth date _____

Nickname _____ Sex ___ Street Address _____ Town _____ Zip _____

Father's Name _____ Birth date _____ Social Security # _____ Occupation/Employer _____

Mother's Name _____ Birth date _____ Social Security # _____ Occupation/Employer _____

Name and Age of Siblings: _____

PARENTS' INFORMATION: ☐ Single ☐ Separated ☐Married ☐ Divorced ☐ Widowed

Contact Email Address _____

Father's Work # _____ Father's Cell # _____ Mother's Work # _____ Mother's Cell # _____

Previous or Family Dentist _____ Telephone _____

Child's Physician _____ Telephone _____

Whom can we thank for referring you _____

FINANCIAL POLICY

Payment Is Due When Services Are Rendered. We accept cash, personal checks, MasterCard, Visa and Care Credit. In the case of divorce or separation, the parent bringing the child to the office will be deemed financially responsible.

APPOINTMENT POLICY

If you are unable to keep an appointment, we ask that you give our office at least 24 hours notice.
Missed appointment fees may be applicable.

INSURANCE INFORMATION

Your insurance policy is a contract between you, your employer and your insurance company. Therefore, you are responsible for understanding your coverage, benefits and yearly maximum. An authorization will be required to bill your dental insurance company. Please complete the following so that we will have this on file.

PRIMARY INSURANCE CARRIER

SUBSCRIBER_____
SUBSCRIBER ID#_____
SUBSCRIBER'S EMPLOYER_____
INSURANCE CARRIER_____
GROUP #_____
CLAIMS ADDRESS_____
CITY_____STATE_____ZIP_____

SECONDARY INSURANCE CARRIER

SUBSCRIBER_____
SUBSCRIBER ID#_____
SUBCRIBER'S EMPLOYER_____
INSURANCE CARRIER_____
GROUP #_____
CLAIMS ADDRESS_____
CITY_____STATE_____ZIP_____

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I am responsible for all copayments, deductibles and rejected charges.

I have read the above information and understand my obligations.

1. MEDICAL HISTORY

2. Does your child have any allergies (Medication, Food)? ☐ YES ☐ NO
   If YES please explain:

3. Has your child been diagnosed with bleeding disorders, heart conditions, seizures, or cancer? If YES please explain: ☐ YES ☐ NO

4. Has your child physician told you that your child needs antibiotic treatment prior to any dental procedure? ☐ YES ☐ NO

5. Has your child been diagnosed with any other medical condition? ☐ YES ☐ NO
   If YES, what is the diagnosed condition?
   If YES, has the above condition lasted more than 12 months? ☐ YES ☐ NO

6. Does your child currently use medication(s) prescribed by a Doctor, other than vitamins? ☐ YES ☐ NO
   If YES please specify:

7. Does your child need **more** medical care, mental health or educational services than is **usual** for most children of the same age? ☐ YES ☐ NO

8. Is your child limited or prevented in any way in his/her ability to do the things that most children of the same age? ☐ YES ☐ NO

9. Does your child need or get special therapy such as physical, occupational or speech therapy? ☐ YES ☐ NO

10. Does your child have any Kind of emotional, developmental or behavioral problems for which he/she needs treatment or counseling? ☐ YES ☐ NO

11. During the past 12 months how often has the child's condition (medical, behavioral, emotional or developmental) affected his/her ability to perform daily activities in school or at home?
    . ☐ Never ☐ Rarely ☐ Usually ☐ Always ☐ Don't know

12. Does your child experience difficulty with any of the following:
    . ☐ Breathing (Respiratory problems) ☐ Hearing ☐ Eyesight ☐ Sleeping
    . ☐ Self care (eating/ dressing/bathing) ☐ paying attention/listening ☐ Speaking/communicating
    . ☐ Anxiety / depression

13. Does your child see a specialist(s) to receive treatment for any condition listed above? ☐ YES ☐ NO
    If YES, please complete the following:
    Doctor's name:
    Specialty field:
    Doctor's Phone number:

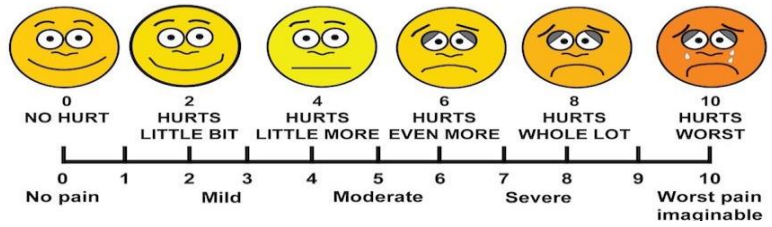
14. Does your child have any of the listed habits? (Currently or had in the past)
    . ☐ Thumbsucking ☐ Mouth breathing ☐ Tongue thrusting ☐ Nail biting ☐ Teeth grinding

15. Does child currently use a baby bottle to drink milk? ☐ YES ☐ NO
    If YES, does the child sleep with the bottle? ☐ YES ☐ NO

16. How often does the child drink apple juice, carbonated drinks (soda), lemonade or other soft drinks?
    . ☐ 2>/day ☐ 1/day ☐ 2>/week ☐ 1/week ☐ 2>/month ☐ 1/month ☐ Never

17. How often does the child eat snacks between meals?
    . ☐ 2>/day ☐ 1/day ☐ 2>/week ☐ 1/week ☐ 2>/month ☐ 1/month ☐ Never

1. DENTAL HISTORY & ORAL HEALTH

2.	Is this the child's first visit to a dentist? If NO, what is the date of last dental exam (mm/dd/yyyy):	☐ YES ☐ NO
3.	Does the child have a **dental problem today**?	☐ YES ☐ NO
4.	Has the child ever received local anesthetic (Novocaine) previously?	☐ YES ☐ NO
5.	Is the child experiencing pain today? If YES, please ask child to select the level of pain **PAIN MEASUREMENT SCALE**  	☐ YES ☐ NO
6.	Who brushes the child's teeth?	☐ CHILD ☐ PARENT ☐ OTHER
7.	How many times per day does the child brush his/her teeth?	☐ 0 ☐ 1 ☐ 2>
8.	Does the child use fluoride based toothpaste?	☐ YES ☐ NO ☐ DO NOT KNOW
9.	How many times per day does the child floss his/her teeth per day?	☐ 0 ☐ 1 ☐ 2>
10.	Does child drink tap water?	☐ YES ☐ NO
11.	Is the tap water at home fluoridated?	☐ YES ☐ NO ☐ DO NOT KNOW

I hereby give permission to Children's Dental Care to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (infections), radiographs, etc.

Signature of legal guardian _____ Date_____

Children's Dental Care
Badrieh Edalatpour, D.M.D.
Pediatric Dentistry
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General Informed Consent

We are asking you to read and sign the following. It means you understand the recommended treatment plan or alternative treatment plans that have been presented to you.

I, the patient of record have been informed by the dentist of the need to undergo dental oral medicine treatment as presented to me, and the relevant information regarding my treatment has been read by me and explained to me. I have been fully informed about the diagnosis, details and estimated costs of recommended treatment and alternatives. I agree I understand that as treatment proceeds there may be a need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I have been informed that success of treatment depends upon my cooperation in keeping schedule appointments, following home care instructions including oral hygiene and dietary instructions, taking prescribed medications, and reporting to my dentist any changes in my health status. I acknowledge that I have not made any warranties or guarantees concerning treatment or its long term success.

I have been informed that a preventive visit consists of prophylaxis, fluoride application and necessary x-rays unless the dental team has been previously informed otherwise.

If the patient is under 18 years or incompetent to consent, a parent or legal guardian must sign this general informed consent.

Patient Name: _____

Parent's Name: _____

Date: _____

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Pediatric Dentistry
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Appointment Cancellation Policy

We strive to render excellent dental care to your child and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your child or children appointment. This allows for other patients to be scheduled into that appointment. If your child/children miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of Children's Dental Care and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name) Mother or Father or Legal Guardian of _____ (child's name), have received a copy of Children's Dental care Appointment Cancellation Policy.

_____ _____

Signature of Parent Date